# Psychiatric Briefs

### Racial Variation in Antidepressant Treatment in a Medicaid Population

*Melfi CA, Croghan TW, Hanna MP, et al.*

***Background:*** Many studies have found racial and socioeconomic variation in medical care for a variety of conditions. Undertreatment of depression for individuals of all races is a concern, but especially may affect vulnerable populations such as Medicaid recipients and minorities. With this study, we examine racial differences in the antidepressant usage in a Medicaid population. ***Method:*** Treatment of 13,065 depressed patients (ICD-9-CM criteria) was examined in a state Medicaid database covering the years 1989 through 1994. Treatment differences were assessed in terms of whether an antidepressant was received at the time of the initial depression diagnosis and the type of antidepressant prescribed (tricyclic antidepressants [TCAs] vs. selective serotonin reuptake inhibitors [SSRIs]), using logistic regression techniques. ***Results:*** African Americans were less likely than whites to receive an antidepressant at the time of their initial depression diagnosis (27.2% vs. 44.0%, $p < .001$). Of those receiving an antidepressant, whites were more likely than African Americans to receive SSRIs versus TCAs. These findings remained even after adjusting for other covariates. ***Conclusion:*** Despite the easy availability of effective treatments, we found that only a small portion of depressed Medicaid recipients receive adequate usage of antidepressants. Within this Medicaid population, limited access to treatment was especially pronounced among African Americans. Racial differences existed in terms of whether an antidepressant was received and the type of medication used.

*(J Clin Psychiatry 2000;61:16–21)*

### Alcoholism in the Elderly

*Rigler SK*

Although underrecognized, alcoholism and alcohol abuse are common problems among the elderly. Late-onset drinking occurs in one third of elderly persons who abuse alcohol, while the other two thirds of elderly alcoholic patients started drinking at a young age. The medical and psychosocial sequelae of early-onset alcoholism in the latter group are compounded by changes associated with aging. Changes in physiology related to aging alter the effects of alcohol at the cellular and organ levels. Also, the interactions of alcohol with numerous drugs prescribed in the elderly may be more serious in this population. The criteria for alcohol abuse and dependence are often more difficult to apply to older persons who are retired or have infrequent social interaction. Screening tools, such as the CAGE questionnaire and the Michigan Alcoholism Screening Test, when supplemented by information about current quantity, frequency, and pattern of alcohol use, can be used by family physicians to identify the older patient with alcohol problems. Older persons should be closely supervised by health care professionals while undergoing detoxification. Age-specific alcohol treatment programs may improve outcomes in some elderly patients.

*(Am Fam Physician 2000;61:1710–1716)*

### Zolpidem for Persistent Insomnia in SSRI-Treated Depressed Patients

*Asnis GM, Chakraburtty A, DuBoff EA, et al.*

***Background:*** Depressed individuals effectively treated with selective serotonin reuptake inhibitors (SSRIs) often report persistent insomnia and require adjunctive sleep-promoting therapy. ***Method:*** Men (N = 40) and women (N = 150) with a mean age of 41.6 years who had persistent insomnia in the presence of effective and stable treatment (at least 2 weeks) with fluoxetine (≤ 40 mg/day), sertraline (≤ 100 mg/day), or paroxetine (≤ 40 mg/day) for DSM-IV major depressive disorder, dysthymic disorder, or minor depressive disorder of mild-to-moderate severity (and score of ≤ 2 on item 3 of the Hamilton Rating Scale for Depression [HAM-D]) participated in this randomized, double-blind, parallel-group study. At study entry, patients were required to score ≤ 12 on the HAM-D. During a 1-week single-blind placebo period, patients had to report on at least 3 nights a latency of ≥ 30 minutes or a sleep time of < 6.5 hours and clinically significant daytime impairment. Patients received either placebo (N = 96) or zolpidem, 10 mg (N = 94) nightly, for 4 weeks and single-blind placebo for 1 week thereafter. Sleep was measured with daily questionnaires and during weekly physician visits. ***Results:*** Compared with placebo, zolpidem was associated with improved sleep: longer sleep times (weeks 1 through 4, $p < .05$), greater sleep quality (weeks 1 through 4, $p < .01$), and reduced number of awakenings (weeks 1, 2, and 4; $p < .05$), together with feeling significantly more refreshed, less sleepy, and more able to concentrate. After placebo substitution, the zolpidem group showed significant worsening relative to pretreatment sleep on the first posttreatment night in total sleep time and sleep quality, reverted to pretreatment insomnia levels on the other hypnotic efficacy measures, or maintained improvement (fewer number of awakenings). There was no evidence of dependence or withdrawal from zolpidem (DSM-IV criteria). Incidence rates of adverse events were similar in both treatment groups (74% and 83% for placebo and zol-

pidem, respectively), but 7 zolpidem patients discontinued compared with 2 placebo patients. ***Conclusion:*** In this defined patient population, zolpidem, 10 mg, was effectively and safely coadministered with an SSRI, resulting in improved self-rated sleep, daytime functioning, and well-being.

*(J Clin Psychiatry 1999;60:668–676)*

### Somatizing Patients, Part 1: Practical Diagnosis

*Servan-Schreiber D, Kolb NR, and Tabas G*

Somatization is common in primary care settings, but is often unrecognized, leading to inordinately high use of health care resources. Patients with somatoform disorders experience emotional distress or stressful life situations as persistent physical symptoms, ranging from mild stress-related complaints to severe debilitation, for which no physiologic explanation can be found. Because traditional medical training focuses on the identification and treatment of organic disorders, most physicians are ill prepared to manage somatoform complaints. Simple reassurance often leads to response in patients whose symptoms are on the low end of the somatization spectrum, but interventions designed to avoid the unnecessary use of costly and potentially dangerous procedures that fail to reduce suffering are necessary in patients who are highly impaired. The authors' approach to a positive diagnosis of somatization requires 2 criteria: several nonspecific symptoms in different organ systems and a chronic course. They cite empathy as essential to the effective relationship between the physician and the somatizing patient.

*(Am Fam Physician 2000;61:1073–1078)*

### Somatizing Patients, Part 2: Practical Management

*Servan-Schreiber D, Tabas G, and Kolb NR*

Symptoms in patients with somatization are caused by emotional distress rather than physiologic dysfunction. The foundation of effective management of the condition begins with the acknowledgment of the patient's suffering and the development of a concerned attitude. Continuity of care with a single primary care physician is beneficial in addressing the management problems that are typical for the somatizing patient. The successful approach to treatment relies on giving an acceptable explanation of the symptoms to the patient, avoiding unwarranted procedures, establishing reasonable treatment goals, and arranging for brief but regular and frequent office visits to provide the patient with regular medical attention that is independent of symptom development. Antidepressant treatment may be of benefit as well as cognitive psychotherapy for willing participants.

*(Am Fam Physician 2000;61:1423–1428)*

### Depression in Women: Diagnostic and Treatment Considerations

*Bhatia SC and Bhatia SK*

Twice as many women experience depression as men. Family physicians should take gender-related biopsychosocial differences and phases of the reproductive cycle into consideration when evaluating and treating depression in women. Although the same diagnostic criteria are used for both genders, the presentation and course may differ in women. Women may more often experience hypersomnia, hyperphagia, guilt, anxiety, weight gain, and comorbid eating disorders. Women may require lower dosages of antidepressants than men because plasma antidepressant concentrations may be higher due to biological differences such as hormone levels and body fat to muscle ratio. The potential effects of antidepressants on a fetus or neonate are a consideration for many depressed women. No increased teratogenic risk from in utero exposure to selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants has been shown by research studies. SSRIs have been shown effective in treating premenstrual dysphoric disorder and other comorbid conditions associated with depression. In women with mild-to-moderate depression, psychotherapy may be the sole treatment, or psychotherapy may be used adjunctively with antidepressant drug therapy. Every patient with depression should be screened for suicidal thoughts, intent, and plan during the initial visit. According to the authors, severely depressed women who have active suicidal thoughts or plans should usually be managed in conjunction with a psychiatrist.

*(Am Fam Physician 1999;60:225–240)*

### Psychosocial Functioning in Women With Premenstrual Dysphoric Disorder Before and After Treatment With Sertraline or Placebo

*Pearlstein TB, Halbreich U, Batzar ED, et al.*

***Background:*** The objective of this study was to evaluate the pretreatment psychosocial functioning of women with premenstrual dysphoric disorder (PMDD) and the effect of sertraline treatment on psychosocial functioning in these patients. ***Method:*** 243 women recruited from 12 university-affiliated sites and meeting DSM-IV criteria for PMDD completed 1 cycle of single-blind placebo and were randomly assigned to flexible-dose sertraline or placebo for 3 cycles. Psychosocial functioning was assessed by the Daily Record of Severity of Problems (DRSP), the Social Adjustment Scale (SAS), and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). ***Results:*** SAS scores during the follicular phase were similar to SAS scores of community norms, whereas the pretreatment SAS and Q-LES-Q scores during the luteal phase were similar to scores of women with depressive disorders. Sertraline was significantly more effective than placebo in improving psychosocial functioning as measured by the SAS, the Q-LES-Q, and the 3 DRSP items of impaired productivity, interference with social activities, and interference with relationships with others. Improvement in psychosocial functioning assessed by SAS and Q-LES-Q correlated with improvement in symptomatology assessed by the Clinical Global Impressions-Improvement (CGI-I) scale and the Hamilton Rating Scale for Depression (HAM-D). Remitters (CGI-I score of 1) were more likely to function better at baseline and showed larger improvements in functioning and quality of life with treatment compared with nonremitters. ***Conclusion:*** Sertraline was superior to

placebo in improving psychosocial functioning in women with PMDD as reflected by SAS, Q-LES-Q, and DRSP measures. Functional improvement correlated with improvement in premenstrual symptomatology and was apparent by the second cycle of treatment. Comparison of pretreatment SAS scores in women with PMDD with the scores of other populations of women documents the degree of luteal phase functional impairment in women with PMDD and a relative absence of follicular phase impairment.

*(J Clin Psychiatry 2000;61:101–109)*

### Mood Stabilizers During Breastfeeding: A Review

*Chaudron LH and Jefferson JW*

***Background:*** The postpartum period is an exceptionally high-risk time for recurrence of depression, mania, or psychosis for women with bipolar disorder. Puerperal prophylaxis with mood stabilizers decreases this risk. To allow patients and clinicians to make informed decisions about mood-stabilizer use during breastfeeding, there is a need for a critical review and analysis of the data. ***Data Sources:*** A search of MEDLINE (1966–1998) and the Lithium Database, Madison Institute of Medicine, was conducted to obtain articles about lithium, valproate, carbamazepine, gabapentin, or lamotrigine use during lactation. Search terms used were *pregnancy*, *teratogenesis*, *breastfeeding*, *lactation*, *breast milk levels* and *lithium*, *anticonvulsants*, *mood stabilizers*. No other search restrictions were used. Unpublished data on gabapentin and lamotrigine were provided by the manufacturers. ***Results:*** The search revealed 11 cases of lithium use during breastfeeding, 8 of which reported infant serum levels. Two cases reported symptoms consistent with lithium toxicity in the infants. Thirty-nine cases of valproate use during breastfeeding were found, 8 of which reported infant serum levels. There was 1 report of thrombocytopenia and anemia in an infant. Fifty cases of carbamazepine use during breastfeeding were found, 10 of which reported infant serum levels. Two infants experienced hepatic dysfunction. One unpublished study of gabapentin in breast milk was found. Three reports of lamotrigine use during breastfeeding were found. ***Discussion:*** Available information remains limited to uncontrolled studies and case reports. Carbamazepine and valproate, but not lithium, have generally been considered compatible with breastfeeding. The overall paucity of data, data confounded by polypharmacy and infant age differences, and adverse reactions reported with all established mood stabilizers dictate a reassessment of these recommendations. We propose that a woman's historical response to medication and the clinical circumstances be the primary considerations when choosing a mood stabilizer during breastfeeding, rather than strict adherence to categorical assignments.

*(J Clin Psychiatry 2000;61:79–90)*

### Compliance With Antidepressant Medication in the Treatment of Major Depressive Disorder in Primary Care: A Randomized Comparison of Fluoxetine and a Tricyclic Antidepressant

*Thompson C, Peveler RC, Stephenson D, et al.*

***Objective:*** Using a randomized study design, the authors evaluated differential compliance with antidepressant medications in a primary care setting. Claims have been made for superior compliance with selective serotonin reuptake inhibitors (SSRIs) over tricyclic antidepressants (TCAs), although no meta-analyses have confirmed this claim in randomized controlled trials. ***Method:*** 152 patients (aged 18–70 years) with DSM-III-R major depressive disorder treated in 10 primary care practices in the United Kingdom were randomly assigned to receive the SSRI fluoxetine or the TCA dothiepin at therapeutic doses in a parallel-group, open-label comparison study of 12 weeks. Compliance measures were pill count, patient-completed questionnaire, and the Medication Event Monitoring System. ***Results:*** Although the differences were not significant, the level of compliance with fluoxetine was numerically higher than the level of compliance with dothiepin on all 3 primary outcome measures. Two measures derived from the Medication Event Monitoring System—survival analysis and the compliance index—showed a significant advantage for fluoxetine. Fluoxetine-treated patients showed superior response on the health transition scale of the 36-item Short-Form Health Survey Questionnaire and numerically greater improvement on the Hamilton Rating Scale for Depression (HAM-D). Those patients in both treatment groups with a superior compliance index were more likely to have improved HAM-D scores by the last study visit. ***Conclusion:*** The authors state that "this study supports recent meta-analyses of SSRIs versus TCAs in finding no significant differences in crude indices of compliance between fluoxetine and dothiepin, despite marked differences in side effect profile and dose regimen." They did find, however, that 2 measures used in a secondary analysis—survival analysis for length of time without a gap in medicine taking and a measure that takes account of prolonged periods of noncompliance—distinguished between the treatments and were associated with improvement in both groups.

*(Am J Psychiatry 2000;157:338–343)*